

BHF

Info-line

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A new electronic industry update brought to you by the Board of Healthcare Funders of Southern Africa

VAT Calculations with regards to the new drug pricing legislation

There has been much uncertainty in the recent past around the VAT calculations relating to the Single Exit Price of Drugs and the related dispensing fee. Whilst the regulations relating to Section 22G of the Medicines and Related Substances Act (ACT 101 of 1965) might read with some ambiguity, the VAT Act is very clear.

The Office of the South African Revenue Services (SARS) has informed the Dept. of Health that, regardless of the ambiguity, the VAT Act supersedes in this case.

The ambiguity stems from the fact that the Single Exit Price includes VAT, whilst the dispensing fee does not include VAT. Hence, it could be interpreted that the regulations imply that VAT may be calculated on VAT. However, SARS points out that this cannot be the case.

Single Exit Price (SEP) definition

“single exit price”, in terms of the regulations, means the price set by the manufacturer or importer of a medicine or Scheduled substance combined with the logistics fee and VAT and is the price of the lowest unit of the medicine or Scheduled substance within a pack multiplied by the number of units in the pack

The method for calculating VAT shown below is the correct method and is consistent with the interpretations of some tax experts with whom BHF has consulted. Hence, between the Dept of Health, SARS and BHF the following has been agreed upon.

1. The SEP is inclusive of VAT.
2. The dispensing fee (either 16%/R16 or 26%/R26) is not inclusive of VAT.
3. Dispensed price = ((SEP - (VAT on SEP)) + (Professional Dispensing Fee)) + VAT

4. The threshold of R100 refers to the threshold based on the (SEP - VAT) number.
5. Therefore, the VAT on the SEP plus the dispensing fee should be calculated as follows:

Step one: VAT should be stripped out of the SEP
Step two: Dispensing fee should be added on to the SEP less the VAT.
Step three: VAT on both amounts combined should be added to give the final price.

Example: A drug with the SEP of R100 would be dealt with as follows:

$$\begin{aligned} \text{R100 less 14\% VAT} &= \text{R87.72} \\ \text{R87.72} + 26\% &= \text{R110.53} \\ \text{R110.53} + \text{VAT of 14\%} &= \text{R126.00} \end{aligned}$$

The above examples highlight the complexity, but at the same time the simplicity of the calculation.

The simple reading of the regulations say that if the SEP = R100, then the R26 dispensing applies, however, when the VAT is removed the SEP becomes R87.72, hence only 26% of R87.72 may be applied as the dispensing fee.

Should a medical scheme, administrator or service provider not apply the calculation as laid out, it is possible that the reimbursement with respect to the dispensing fee would be higher (by around 3%) than permitted in terms of the Act. The medical scheme/administrator would therefore be breaking the law.

It is important to stress that this is not merely a BHF interpretation but the methodology laid down by SARS and the Dept. of Health.

Medical Schemes all set for ICD-10

The vast majority of medical schemes who participated in a recent BHF survey are confident that they will be able to receive ICD-10 codes for all services from all provider disciplines by 1 January 2005. This survey forms part of a broader survey conducted by the National ICD-10 Implementation Task Team.

The recent survey, which received responses from 108 medical schemes out of 133 originally targeted, was aimed at assessing readiness to implement the ICD-10 diagnostic coding system next year. The ICD-10 diagnostic coding system is to become compulsory for the 270 hospital-based prescribed minimum benefits, including 25 chronic conditions.

Questions included the use of electronic versions, levels of training, system limitations, updates and communication.

Asked whether employees doing the capturing of data had a medical background, 80% of respondents said they used both medical and non-medical staff while 20% indicated they were using either medical or non-medical staff. According to the survey, 102 of the medical schemes had confidentiality agreements in place, while a whopping 107, out of 108, indicated that staff members were sufficiently trained to implement ICD-10 coding.

Eighty-two medical schemes indicated that they have received formal training on ICD-10 coding while 71% employed an electronic version of the ICD-10 coding list.

Only 34% of the schemes admitted to using cheat sheets or shortlists to speed up the process while 27 schemes developed their cheat sheets in-house.

Fifty-six schemes indicated that they could accommodate a claim with one primary ICD-10 code and up to 29 secondary ICD-10 codes. The other 52 schemes indicated that they were able to accommodate one primary ICD-10 code and up to 15 secondary ICD-10 codes.

Only two schemes admitted to having system limitations, while only one believed that the provider sector was not ready to implement the coding system. With regard to training, 82 medical schemes indicated the need either for first time or continual training. All the schemes that participated wanted regular communication and updates on ICD10.

ICD-10 Training

The Department of Health has decided to adopt the ICD-10 diagnostic coding system as the standard for the public and private health sectors. The system is generally accepted in the industry as facilitating funding and reimbursement. It has already been adopted by the National Health Information System of South Africa. As the Department of Health points out, it promotes the storage, analysis and communication of healthcare data. The system will come into force fully in 2005 and practitioners will be reimbursed only if they use ICD-10 as the diagnostic coding standard for PMBs. This of course is of particular importance where the 300-odd PMBs are concerned for which legislation now obliges schemes to pay in full. ICD-10 codes are additional and do not replace the NRPL codes.

The need for widespread training in the use of ICD-10 and its benefits by credible institutions, therefore, is crucial. BHF has been approached by an institution who is an accredited professional ICD-10 Coder and who is offering a computer based training programme which will provide the learner with an understanding of how to assign ICD-10 diagnostic codes to a claim, patient records and/or a coding database. The course takes the form of four modules, namely (i) an introduction to ICD-10, (ii) principles and structure of ICD-10, (iii) rules and conventions of ICD-10, and (iv) chapter specific coding guidelines and practical exercises.

A face-to-face, intermediate course for learners who have completed the Introduction course to basic ICD-10 coding and who are competent in basic anatomy, physiology and medical terminology is also available through this institution.

The courses all have formative and summative assessments. Healthcare providers who qualify for CPD points will also receive six CPD points on completion of the course.

Candidates wishing to participate must have completed a pre-assessment some 4-6 weeks prior to the course to determine their level of competence. Practical exercises as well as mid-course assessments are conducted during the course. A post-course assessment is conducted to enable the candidate to obtain an attendance certificate. Participants are given three attempts to become competent.

For further information on this course, please call 011 7839819.

The ICD-10 Task Team, composed of members of the Council for Medical Schemes, the National Department of Health and industry stakeholders, is recommending a one to two-year course for those wishing to become professional coders. This will include coding up to an advanced level.

Better Benefit Design

In the past the major focus of the Benefit and Risk department within BHF was on interaction with industry stakeholders around the annual publication of the scale of benefits which schemes would reimburse to members for medical services. Since the publication of this guide (National Reference Price List) has been taken over by the Council for Medical Schemes, the department has not only worked with the Council in evaluating the impact of changes in schemes but has also turned its focus towards improving the definition of benefits so that they are medically more logical.

For example, hospital benefits were usually described as "100% of hospital care", without any qualification concerning the medical necessity or appropriateness of the care provided. The fee-for-service fee schedules incentivise wasteful practices like substituting disposable equipment for re-usable equipment, and lack of guidelines for quality care promoted the use of high intensity care when good general ward care was adequate for the patient's clinical status. Addressing these anomalies and providing guidelines for appropriate care are some of the important new areas of focus for the benefit and risk department.

The prescribed minimum benefits are also an important issue for medical schemes as new regulation requires that care for these conditions be covered in full, with no co-payments, and may not come from a savings

account. The B & R department at BHF has been working on a set of funding guidelines to assist schemes to standardize the basic additional care which must be covered over and above the usual scheme benefits. These will be submitted to the Council shortly, along with new recommendations covering the minimum level of care for birth.

The very high caesarean section rate in private sector in South Africa (64% compared with 6% in Ireland) has prompted the department to look critically at the factors related to these statistics. After careful examination of the data relating to birthing methods in South Africa and other countries the sub-committee working on this issue will recommend to the Council for Medical Schemes that the prescribed minimum benefit for normal pregnancy and birth should be delivery by a mid-wife. Midwife care in pregnancy, birth and after birth provides many advantages including higher rates of successful breast feeding. It is recommended that, in addition to the midwife fees, schemes should cover two visits to an obstetrician during the pregnancy, and obviously, cover the costs of specialist delivery where the midwife refers the patient. Patients would continue to have the freedom to choose their level of care, but the minimum benefit reimbursement for normal pregnancy and birth would be at the midwife level.

A Health Charter for South Africa

A summary of BHF's submission to the Minister of Health

The BHF submission on the health charter presented the view that for the charter to be truly successful, there should be active cooperation between the public and private health sectors which would promote a climate in which the two sectors could work together, ensure rational use of resources and promote high quality care at lowest possible costs. Issues of EQUITY, ACCESS and COST-EFFECTIVENESS are all critical areas in health care transformation, but are even more critical when the issue of growth of medical scheme cover is taken into consideration. These issues are also critical in relation to the implementation of a Social Health system. The BHF submission emphasised that these are foundations on which the charter is developed.

Further aspects of the BHF submission include:

- Achievement of health goals and setting of targets for improved health care outcomes. It is critical that SA is able to benchmark itself as a country, by establishing a baseline health outcomes survey. This must then be the foundation on which transformation occurs. Following that, targets should be set and realised.
- Evidence-based/researched approach to healthcare priority setting.
- Access to and equity in Health care for all of the citizens of South Africa.
- Mechanisms of improved cost-effectiveness in the delivery and financing of healthcare, informed by mechanisms that foster a culture of cost-effective but quality health care.
- Exploration and creation of an enabling framework to improve growth in the Private Health Sector.
- The establishment of Public-Private interactions that could foster improved healthcare objectives. Whilst it is acknowledged that this is an area of great weakness, there is a need for the charter to explore and set out the enabling framework.

- Human resource development. A typical charter looks at issues of human resource empowerment. Employment equity in decision-making and management structures is needed here, clear targets need to be set and achieved as part of a broader transformation agenda. Of equal importance is the fact that health care delivery is still a labour intensive task. Without people we cannot deliver healthcare. Hence, the charter needs to look aggressively at our needs as a unified health sector, address issues of internal and external migration and conditions of employment. This should be encapsulated within an over-riding human resource strategy for the public and private sectors.
- Sustainability of the Health care System
- Transparency in business practices and pricing of services. It must be stressed that the private sector needs to be self-sufficient, vibrant and meet the objectives of the health system. However, to do so it must function within a for-profit environment.

The most critical concern is that, within the medical schemes industry, there is a lack of growth, i.e. the fact that the number of people who have access to medical scheme cover has been stagnant for the past few years. This is characterised by the mis-alignment of incentives within the private health sector. There are fundamental flaws in both the financing and provision elements. Currently, there is very little incentive to contain costs within the provider environment. The balance of power currently sits firmly with the providers, be they hospitals, or health professionals. Medical schemes are 'price takers' in the current model. An option to pursue would be to look at the de-mutualisation of medical schemes, whereby existing members become shareholders in the scheme (in effect a limited for profit model). Obviously, the necessary checks and balances need to be in place. Were medical schemes for-profit, with restrictions on reserving, etc, there would be greater incentive not to pass on costs, but rather to contain them.

Forensic Management Unit helps curb healthcare fraud

In August 2003, the Forensic Management Unit (FMU) was launched under the auspices of the Board of Healthcare Funders with the participation and support of well over 90% of the medical healthcare industry, including both funders and providers. This figure now stands at some 95%. The FMU also enjoys the participation of regulatory bodies, professional councils and professional associations which ensures that the methods used for identifying, investigating and dealing with fraudulent claims, are fair and equitable and that constitutional rights of individuals are never breached.

Fraud and other inappropriate behaviour is higher in the healthcare sector than any other sector in the country. At an estimated 10%-20% of the annual healthcare spend, it amounts to about R8 billion and constitutes one of the key drivers of spiralling medical aid costs.

Among the main reasons for fraud to date has been the lack of visible policing and the public perception that one can "get away with" fraud. The fee-for-service business model also tends to encourage fraud and inappropriate behaviour.

Despite its fledgling status, the FMU has made significant progress. It has established three key databases to deal with fraudulent medical scheme members, employees of medical schemes and administration organisations and healthcare providers. This will ensure that all duplication is avoided as all participants of the unit have access to these databases. Investigators are able to pool information and co-operate on all cases. Fraudsters find it increasingly difficult to commit their crimes because once exposed by one medical scheme, they become known to the entire industry. Investigations are conducted according to a carefully delineated legal framework.

Typical examples of fraud which the unit deals with:

- Where pharmacies and members collude to buy groceries or other goods on the medical scheme card
- Where healthcare practitioners and members collude and the provider gives cash to the patient and then claims for some treatment/consultation from the medical scheme
- Where healthcare practitioners submit false claims to the medical scheme
- Where practitioners claim for services never rendered
- Where practitioners claim for reimbursable goods but issue non-reimbursable goods
- Employees of medical schemes take kickbacks from providers for processing payment without first scrutinising them
- Where members lend their medical scheme cards to non-dependants

The FMU's main objective is to prevent fraud and change inappropriate patterns of behaviour. It operates within a strict legal framework according to jointly determined protocols and procedures in investigating, assessing and punishing fraud, ensuring that the rights of all individuals under investigation are safeguarded. A

common language among all participants provides for duly constituted and consistent decision-making. A key strategic objective of the unit is to lobby for specific healthcare fraud legislation with dedicated prosecutors and courts where there is a thorough understanding of the medical healthcare industry – similar to the False Claims Courts in the USA.

Previously, those found guilty of fraud were merely subject to repayment of sums defrauded and some organization even made use of non-disclosure clauses to recoup money without notifying professional bodies. The FMU has changed that. Not only is money recouped, but the guilty parties are registered on a database and made known to the entire private healthcare industry. Peer review is also used to encourage behavioural change.

The FMU is not restricted to current issues and investigations. It promotes a focused strategic objective of examining new trends and developments and keeping a finger on the pulse of new legislation and regulations, thereby adopting a proactive approach in identifying unintended consequences of legislation and making sure that appropriate measures are put in place to deal with possible fraud.

Industry tip-off line 0800 633 633.

Bulletin Board

The South African Depression and Anxiety Group (SADAG), would like to advise you that they will host Dr. Ken Liberto (USA), a world expert on the impact of mental health care for medical aid schemes, in South Africa in October and November. Dr. Liberto is an expert in the field of Parity in Mental Health. He has worked in Vermont for over 10 years and has convinced insurers that the cost required for giving parity to mental health patients is substantially less than originally expected. He has proven that where parity takes place, not only does it decrease depression, but "it reduces the stigma of mental illness" Vermont is the only state in America to have passed parity

through his initiative and his book *"Fighting for parity in an age of incremental health care reform"* explains the rationale and advantages of taking this route. He has spoken at conferences throughout America and Europe. We would like to invite you to a breakfast meeting to put your questions to him:

Date: Friday 29 October

Time: 08h00-11h00

Venue: BHF Offices, Indaba Room, 37 Bath Avenue, Rosebank.

To RSVP please e-mail zane1@hargray.com or call Roshni on 011.783.1474.

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